CHAPTER V

BILLING INSTRUCTIONS

CHAPTER V
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CHAPTER V
BILLING INSTRUCTIONS

REIMBURSEMENT RATES

The reimbursement for case management is based on an hourly fee billed to DMAS by the provider agency for only those contacts made directly by the case manager, not by any individuals supervised by the case manager interacting with the AIDS waiver recipient. An hourly rate of $15 per hour ($20 per hour in Northern Virginia) up to a maximum amount of 10 hours of case management rendered in any month has been established. This fee must cover all expenses associated with the delivery of case management services. The hourly reimbursement rate is considered by DMAS as payment in full for all administrative costs that the provider agency incurs. The provider is instructed to total all case management interactions completed during one calendar month and submit a bill to DMAS for the whole number of hours substantiated by the provider's documentation for that month (round to the nearest hour).

AUTHORIZATION

The nursing home pre-admission screening committee shall document the amount of case management service needed on the individual's plan of care. Services in the plan of care are certified as medically necessary by the signatures of the physician and other members of the multidisciplinary screening team and are approved by DMAS prior to implementation. Upon DMAS review and approval of the plan of care, the nursing home pre-admission screening committee shall send a copy of the authorization package to the case manager provider.

MEDICAID INVOICES FOR CASE MANAGEMENT SERVICES

The use of the appropriate billing invoice depends upon the type of billing transaction being completed. Listed below are the two (2) billing forms that are used. Examples of these forms are included in this chapter.

- Practitioner Invoice, DMAS-12
- Practitioner Adjustment Invoice, DMAS-220

Submission of Billing Invoices

Case management providers are instructed to submit claims with a beginning date as that of the first case management service offered in the month and the end date as the date of the last case management service rendered within that calendar month. Invoices must include only allowable charges for the number of hours for services rendered during the calendar month. Any charges submitted prior to the date authorized by DMAS as the begin date will be rejected. Invoices and adjustments must be submitted in the green-edged, self-addressed envelope provided by DMAS. The provider copy must be retained by the provider for record keeping. All invoices must be mailed with proper postage; messenger or hand deliveries will not be accepted. Invoices and adjustments should never be mailed to the Department of Medical Assistance Services address; this will only delay processing. Provider agencies should allow at least three to four weeks for claims processing.

TIMELY FILING OF CLAIMS

Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 15 days from the last date of service or discharge. Federal financial participation is not available for claims which **are not** submitted within 12 months from the date of the service. Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- Retroactive Eligibility - Medicaid may make payment for services rendered more than 12 months before the claim is submitted when the claims are for a recipient who has been determined retroactively eligible for Medicaid. Applicants will be found eligible for Medicaid for up to three months prior to the month of application if the recipient was eligible during this period of time. If the individual received Medicaid-covered services during the retroactive period, Medicaid will accept and process the claim.

  When the provider did not have knowledge of the Medicaid eligibility of the person prior to rendering the care or service, he has 12 months from the date he is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care or services during this retroactive period are notified by a letter from the local social services department. The practitioner may submit a claim which is more than 12 months from the date of service but is not more than 12 months from the date of the notification of the retroactive eligibility. A copy of the letter from the social services department indicating the date of notification of the retroactive eligibility must be attached to the claim.

- Rejected or Denied Claims - Rejected or denied claims which have been submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the invoice as explained under the Instructions for Completion of the Department of Medical Assistance Services Invoice, DMAS-12, elsewhere in this chapter.

  - Explain the reason for the late submission in the Remarks section of the invoice and **attach** written documentation to verify the explanation. This documentation may be photocopies of invoices or denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period.

  - Submit the claim in the usual manner using the preprinted envelopes supplied by Medicaid or by mailing the claim to:

    Practitioner
    Department of Medical Assistance Services
    Post Office Box 27444
    Richmond, Virginia 23261-7444

    The first copy of a multicopy invoice form should be submitted in the preaddressed Medicaid envelope. The additional copies are retained by the provider for record keeping. All invoices must be mailed (proper postage is the responsibility of the provider and will help prevent mishandling); messenger or hand deliveries will not be accepted.

- Exceptions - The state Medicaid agency is required to adjudicate all claims within 12 months of receipt, except in the following circumstances:

  - The claim is a retroactive adjustment paid to a provider who is reimbursed under a retrospective payment system.

  - The claim is related to a Medicare claim which has been filed in a timely manner, and the Medicaid claim is filed within six months of the disposition of the Medicare claim.

- This provision applies when Medicaid has suspended payment to the provider during an investigation and the investigation exonerates the provider.

- The payment is in accordance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of these specified criteria.

REMITTANCE VOUCHER (Payment Voucher)

DMAS sends a remittance voucher with each payment. This voucher is a listing of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five years.

The check is the last item in the envelope. The remittance voucher includes an address sheet which has been added for security purposes. The address sheet contains the provider's name and address. The remittance voucher contains a space for special messages from DMAS.

Participating providers are encouraged to monitor the remittance vouchers for special messages that will expedite notification on matters of concern. This mechanism may be used to alert providers on matters that may relate to:

- Pending implementation of policies and procedures

- Sharing clarification on a concern expressed by a provider

INSTRUCTIONS FOR THE USE OF THE HCFA-1500 (12-90) BILLING FORM

To bill for services, the Health Insurance Claim Form, HCFA-1500 (12-90), invoice form must be used. The following instructions have numbered items corresponding to fields on the HCFA-1500. **The required fields to be completed are printed in boldface. Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information.**

Instructions for the Completion of the Health Insurance Claim Form, HCFA-1500 (12-90), Billing Invoice

The purpose of the HCFA-1500 is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid recipients. (A sample of a completed HCFA-1500 claim form follows the instructions for its use.)

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box.**
1a	**REQUIRED**	**Insured's I.D. Number – Enter the 12-digit Virginia Medicaid Identification number for the recipient receiving the service.**
2	**REQUIRED**	**Patient's Name – Enter the name of the recipient receiving the service as it appears on the identification card.**
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex

Locator		Instructions
9c	NOT REQUIRED	Employer's Name or School Name
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: – Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED.)** **a. Employment? b. Auto Accident? c. Other Accident? (This includes schools, stores, assaults, etc.)**
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form or if procedure modifier "22" (unusual services) is used.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	NOT REQUIRED	Insurance Plan or Program Name
11d	NOT REQUIRED	Is There Another Health Benefit Plan?
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**CONDITIONAL**	**Name of Referring Physician or Other Source**
17a	**CONDITIONAL**	**I.D. Number of Referring Physician – Enter the 7-digit Virginia Medicaid number of the referring physician. See the following pages for special instructions for your services.**
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Reserved for Local Use
20	NOT REQUIRED	Outside Lab?

Locator		Instructions
21	REQUIRED	**Diagnosis or Nature of Illness or Injury – Enter the appropriate ICD–9 CM diagnosis which describes the nature of the illness or injury for which the service was rendered.**
22	CONDITIONAL	**Medicaid Resubmission – Required for adjustment and void. See the instructions for Adjustment and Void Invoices.**
23	NOT REQUIRED	Prior Authorization Number
24A	REQUIRED	**Dates of Service – Enter the from and thru dates in a 2–digit format for the month, day, and year (e.g., 04/01/92). DATES MUST BE WITHIN THE SAME CALENDAR MONTH.**
24B	REQUIRED	**Place of Service – Enter the 2–digit HCFA code which describes where the services were rendered. See the Place of Treatment Codes list following the instructions for the appropriate code entry.**
24C	REQUIRED	**Type of Service – Enter the one–digit HCFA code for the type of service rendered. See the code list following the instructions for the appropriate code entry.**
24D	REQUIRED	**Procedures, Services or Supplies** **CPT/HCPCS – Enter the 5–character CPT/HCPCS Code which describes the procedure rendered or the service provided. Use code Z9440 for case management services.** Modifier – Enter the appropriate HCPCS/CPT modifiers if applicable. See the list of modifiers following the instructions for the appropriate entry.
24E	REQUIRED	**Diagnosis Code – Enter the entry identifier of the ICD–9CM diagnosis code listed in Locator 21 as the primary diagnosis. NOTE: Only one code is processable.**
24F	REQUIRED	**Charges – Enter your total usual and customary charges for the procedure/services. See the special instructions following these instructions if applicable for your service.**

Locator		Instructions
24G	REQUIRED	**Days or Unit – Enter the number of times the procedure, service, or item was provided during the service period. See the pages following the instructions for special instructions if applicable to your service.**
24H	CONDITIONAL	**EPSDT or Family Plan – Enter the appropriate indicator. Required only for EPSDT or family planning services.** **1 – Early and Periodic, Screening, Diagnosis and Treatment Program Services** **2 – Family Planning Service**
24I	CONDITIONAL	**EMG (Emergency) – Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.**
24J	REQUIRED	**COB (Primary Carrier Information) – Enter the appropriate code. See special instructions if required for your service.** **2 – No Other Carrier** **3 – Billed and Paid** **5 – Billed, No Coverage**
24K	REQUIRED	**Reserved for Local Use – Enter the dollar amount received from the primary carrier if Block 24J is coded "3". See special instructions if required for your service.**
25	NOT REQUIRED	Federal Tax I.D. Number
26	OPTIONAL	**Patient's Account Number – Seventeen alpha-numeric characters are acceptable.**
27	NOT REQUIRED	Accept Assignment
28	NOT REQUIRED	Total Charge
29	NOT REQUIRED	Amount Paid
30	NOT REQUIRED	Balance Due

Locator		Instructions
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials – The provider or agent must sign and date the invoice in this block.**
32	NOT REQUIRED	Name and Address of Facility Where Services Were Rendered
33	**REQUIRED**	**Physician's, Supplier's Billing Name, Address ZIP Code & Phone # – Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your 7-digit Virginia Medicaid provider number in the PIN # field. Ensure that your provider number is distinct and separate from your phone number or ZIP Code.**

Instructions for the Completion of the Health Insurance Claim Form, HCFA-1500 (12-90), as an Adjustment Invoice

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, HCFA-1500 (12-90), except for the locator indicated below.

Locator 22 — **Medicaid Resubmission**

Code – Enter the 3-digit code identifying the reason for the submission of the adjustment invoice.

- **523** Primary Carrier has made additional payment
- **524** Primary Carrier has denied payment
- **525** Accommodation charge correction
- **526** Patient payment amount changed
- **527** Correcting service periods
- **528** Correcting procedure/service code
- **529** Correcting diagnosis code
- **530** Correcting charges
- **531** Correcting units/visits/studies/procedures
- **532** IC reconsideration of allowance, documented
- **533** Correcting admitting, referring, prescribing, provider identification number

Original Reference Number – Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each HCFA-1500 submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

Instructions for the Completion of the Health Insurance Claim Form, HCFA-1500 (12-90), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, HCFA-1500 (12-90), except for the locator indicated below.

Locator 22 — Medicaid Resubmission

Code – Enter the 3-digit code identifying the reason for the submission of the void invoice.

542	Original claim has multiple incorrect items
544	Wrong provider identification number
545	Wrong recipient eligibility number
546	Primary carrier has paid DMAS maximum allowance
547	Duplicate payment was made
548	Primary carrier has paid full charge
551	Recipient not my patient
552	Void is for miscellaneous reasons
560	Other insurance is available

Original Reference Number – Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each HCFA-1500 submitted as a Void Invoice. (Each line under Locator 24 is one claim.)

PLACE OF SERVICE CODES

HCFA-1500 CODE

00-10	Unassigned
11	**Office location**
12	**Patient's home**
13-20	Unassigned
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room
24	Ambulatory surgical center
25	Birthing center
26	Military treatment center
27-30	Unassigned
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
35-40	Unassigned
41	Ambulance - land
42	Ambulance - air or water
43-50	Unassigned
51	Inpatient psychiatric facility
52	Psychiatric facility - partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57-60	Unassigned
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
63-64	Unassigned
65	End stage renal disease treatment facility
66-70	Unassigned
71	State or local public health clinic
72	Rural health clinic
73-80	Unassigned
81	Independent laboratory
82-98	Unassigned
99	Other unlisted facility

TYPE OF SERVICE CODES

CODE	DESCRIPTION
1	**Medical care**
2	Surgery
3	Consultation
4	Diagnostic x-ray
5	Diagnostic laboratory
6	Radiation therapy
7	Anesthesia
8	Assistance at surgery
9	Other medical care
0	Blood or packed red cells
A	Used DME
F	Ambulatory surgical center
H	Hospice
L	Renal supplies in the home
M	Alternate payment for maintenance dialysis
N	Kidney donor
V	Pneumococcal vaccine
Y	Second opinion on elective surgery
Z	Third opinion on elective surgery

PROCEDURE MODIFIERS

HCPCS/CPT	
TC	Technical component
22	Unusual service
26	Professional component
50	Bilateral procedure
51	Multiple procedures
52	Reduced services
75	Concurrent care
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant surgeon

PROCEDURE MODIFIERS FOR EPSDT

MODIFIER CODE

H	No abnormalities found, no treatment required, and no referral required
K	Abnormality found, treatment has been initiated by myself, and no other referral required
T	* Abnormality found, treatment has been initiated by myself, and referral to another practitioner has been made
U	* Abnormality found, no treatment has been initiated by myself, and referral to another practitioner has been made
W	Abnormality found, no treatment has been made at this time, referral to myself for treatment within the next 120 days
Y	Abnormality found, treatment/referral has been refused by the recipient or the responsible adult in the case
Z	Abnormality found, no treatment has been initiated, no referral has been made. The recipient is already under care.

* When abnormality referrals are made by a physician to other practitioners, the names of the practitioners and the appointment dates must be provided on an attachment and the word "ATTACHMENT" entered in Locator 10d.

SAMPLE

COMPLETED HEALTH INSURANCE CLAIM FORM (HCFA-1500)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — (Medicare #) / (Medicaid #) / (Sponsor's SSN) / (VA File #) / (SSN or ID) / (SSN) / (ID) — X	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123-456-789-101
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN E.	3. PATIENT'S BIRTH DATE MM DD YY; SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES / X NO	a. INSURED'S DATE OF BIRTH MM DD YY; SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M F	b. AUTO ACCIDENT? PLACE (State): YES / X NO	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO — If yes, return to and complete item 9 a-d
12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED / DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES / NO; $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 042 00		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO
2. / 3. / 4.		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 01 92	02 28 92	12	1	Z9440		1	30 00	2			2	
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Mary Smith SIGNED / DATE 5/5/92	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Aids Service Organization, Inc. 9242 West Main Street Anytown, VA 24033 PIN# 8740000 GRP#		

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8 88) — PLEASE PRINT OR TYPE — FORM HCFA-1500 (12 90) FORM OWCP-1500 FORM RRB-1500

SAMPLE

COMPLETED HEALTH INSURANCE CLAIM FORM (HCFA-1500) AS AN ADJUSTMENT INVOICE

PLEASE DO NOT STAPLE IN THIS AREA [redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER ( ) (Medicare #) (X) (Medicaid #) ( ) (Sponsor's SSN) ( ) (VA File #) ( ) ( ) (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 544519000122
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LEE, MAY	3. PATIENT'S BIRTH DATE MM DD YY SEX M ( ) F ( )
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ( ) Spouse ( ) Child ( ) Other ( )
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. PATIENT STATUS Single ( ) Married ( ) Other ( ) Employed ( ) Full-Time Student ( ) Part-Time Student ( )
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ( ) YES (X) NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ( ) F ( )	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ( ) F ( )	b. AUTO ACCIDENT? PLACE (State) ( ) YES (X) NO
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ( ) YES (X) NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ( ) YES ( ) NO If yes, return to and complete item 9 a-d	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. RESERVED FOR LOCAL USE	
20. OUTSIDE LAB? ( ) YES ( ) NO $ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 461 1 2. 466 1 3. 4.	22. MEDICAID RESUBMISSION CODE 525 ORIGINAL REF. NO. 111111111
	23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 05 01 92	05 01 92	11	1	99212		1	35 00	1			3	15.00
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO. 12345678	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ( ) YES ( ) NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED [signature] DATE 5/6/92	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (804)999-9999 JOHN JONES, MD 23 MAIN STREET TOWN, VA 23200 PIN# 1234567 GRP#		

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

SAMPLE

COMPLETED HEALTH INSURANCE CLAIM FORM (HCFA-1500) AS A VOID INVOICE

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) X / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 544519000122
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LEE, MAY	3. PATIENT'S BIRTH DATE MM DD YY / SEX M / F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M / F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M / F	b. AUTO ACCIDENT? YES / X NO / PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES / NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 461 1 2. 466 1 3. 4.		22. MEDICAID RESUBMISSION CODE: 544 ORIGINAL REF. NO.: 111111111
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 05 01 92	05 01 92	11	1	99212		1	25 00	1			3	15.00
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.: 12345678	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Mary DATE 5/6/92	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: (804) 999-9999 JOHN JONES, MD 23 MAIN STREET TOWN, VA 23200		
			PIN# 1234567		GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

SPECIAL BILLING INSTRUCTIONS

CLIENT MEDICAL MANAGEMENT PROGRAM

The primary care physician bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. Covered outpatient services excluded from this requirement include: renal dialysis clinic services, routine vision care services, BabyCare services, personal care services (respite care or adult day health care), ventilator-dependent services, EPSDT, and prosthetic services.

All services should be coordinated with the primary health care provider whose name appears on the recipient's eligibility card. Other DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

A physician treating a restricted recipient as a physician covering for the primary care physician or on referral from the primary care physician must place the primary care physician's Medicaid provider number (as indicated on the recipient identification card) in Locator 17a and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70, or for remarks as appropriate.
17a	When a restricted recipient is treated on referral from the primary physician, enter the primary care physician's Medicaid provider number (as indicated on the card) and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. Write "ATTACHMENT" in Locator 10d.
24I	When a restricted recipient is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

SPECIAL BILLING INSTRUCTIONS

MEDALLION

Primary Care Providers (PCP) bill for services on the Health Insurance Claim Form, HCFA-1500 (12-90). The invoice is completed and submitted according to the instructions provided in the Medicaid Physician Manual.

To receive payment for their services, referral providers authorized by a client's PCP to provide treatment to that client must place the Medicaid Provider Identification Number of the PCP in Locator 17a of the HCFA-1500. Subsequent referrals resulting from the PCP's initial referral will also require the PCP Medicaid provider number in this block.

PATIENT INFORMATION FORM (DMAS-122)

Purpose

This form is used by a local Department of Social Services and Medicaid providers to exchange information on:

- The responsibility of an eligible client to make payment toward the cost of care
- The admission, discharge, or death of the client
- Other information known to the provider that might involve a change in the eligibility or patient pay responsibility

The form shall be prepared by the provider to request a Medicaid number, eligibility determination, or confirmation of the patient pay or to notify the local Department of Social Services of changes in the client's circumstances. A new form is to be prepared by the local Department of Social Services at the time of each redetermination of eligibility and whenever there is any change in the client's circumstances that results in a change in the amount of patient pay. (See Appendix B for a copy of the form and the instructions for its completion.)

Disposition of Copies

The case manager will initiate the form to notify the local Department of Social Services that the individual has been admitted to the program and to provide the beginning date of service. Upon the determination of eligibility, the DMAS-122 will be returned to the case manager with the following information:

- The client's financial responsibility toward the cost of care (even if there is none)
- The amount and sources of finances

There must be a completed DMAS-122 form in the client's file prior to billing DMAS.

REQUESTS FOR BILLING MATERIALS

The Provider Enrollment/Certification Unit of the Department of Medical Assistance Services is responsible for the distribution of all forms pertaining to home and community-based care services.

The DMAS Request for Forms/Brochures form (DMAS-161) or Request for Billing Supplies form (DMAS-160), as appropriate, must be used by providers to order the DMAS-12, DMAS-220, or DMAS-122 forms. (Examples of these ordering forms are included as Exhibits V.3 and V.4.) A six-month supply of forms should be ordered at least three weeks prior to the anticipated need.

Submit the Request for Forms/Brochures or Request for Billing Supplies to:

DMAS Order Desk
North American Marketing
3703 Caroline Avenue
Richmond, Virginia 23222

Any requests for information or questions concerning the ordering of forms should also be directed to the address above, or call 329-4400 in the Richmond area or 1-804-329-4400 from all other areas.

INQUIRIES CONCERNING BILLING PROCEDURES

Inquiries concerning covered benefits, specific billing procedures, or remittances should be directed to the Medicaid HELPLINE number:

786-6273	Richmond Area
1-800-552-8627	All Other Areas

The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on State holidays.

EXHIBIT V.3

REQUEST FOR BILLING SUPPLIES (DMAS-160)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
REQUEST FOR INVOICES/ENVELOPES

Name_____ Date _____

Provider Number_____ Contact Person _____

Telephone # (_____) _____
(Area Code)

Check As Appropriate

_____ Please forward preprinted invoices as indicated below.
_____ Please forward invoices suitable for computer use as indicated below.
_____ Other (See Order Below)

Quantity:	Dental:
_____	Form 701 Invoice
_____	Form 702 Invoice Adjustment
_____	Form 704 Preauthorization Req
_____	Form 703 Envelope
	Home Health Agency
_____	Form 92 Invoice
_____	Form 219 Invoice Adjustment
_____	Form 662 Envelope
	Hospital:
_____	Form 660 Envelope
	Laboratory
_____	Form 123 Invoice
_____	Form 230 Invoice Adjustment
_____	Form 665 Envelope
	Nursing Home:
_____	Form 215 Invoice
_____	Form 262 Invoice Adjustment
_____	Form 661 Envelope
	Personal Care: NOT PREPRINTED
_____	Form 93 Invoice
_____	Form 94 Invoice Adjustment
_____	Form 659 Envelope

Quantity:	Pharmacy:
_____	Form 173 Drug Claim Ledger
_____	Form 228 Drug Claim Adjustment
_____	Form 664 Envelope
	Practitioner:
_____	Form 12 Invoice
_____	Form 220 Invoice Adjustment
_____	Form 663 Envelope
	Screening (EPSDT):
_____	Form 25 Invoice
_____	Form 26 Invoice Adjustment
_____	Form 660 Envelope
	Special Service: NOT PREPRINTED
_____	Form 199 Invoice
_____	Form 233 Invoice Adjustment
_____	Form 666 Envelope
	Title XVIII: NOT PREPRINTED
_____	Form 30 (Medicare) Deductible and Coinsurance Invoice
_____	Form 31 Invoice Adjustment
	Transportation: NOT PREPRINTED
_____	Form 7 Invoice
_____	Form 8 Invoice Adjustment
_____	Form 666 Envelope

Please return this form to: Provider Enrollment/Certification Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

DMAS-160 R 11/90

EXHIBIT V.4

REQUEST FOR FORMS/BROCHURES (DMAS-161)

Department of Medical Assistance Services
Request for Forms/Brochures

Name_____ Date _____

Provider Number_____ Contact Person _____

Telephone # (_____) _____
(Area Code)

Quantity	Form Number	Form Name
_____	DMAS-13	Medicaid Driver Registration Form
_____	DMAS-15	Second Opinion for Surgery Form
_____	DMAS-16	Maternity Risk Screen
_____	DMAS-17	Infant Risk Screen
_____	DMAS-20	Consent Form for Release of Information Rev 1/90
_____	DMAS-50	Maternal Care Coordinator Record
_____	DMAS-51	Infant Care Coordinator Record
_____	DMAS-52	Care Coordination Service Plan
_____	DMAS-53	Pregnancy Outcome Report
_____	DMAS-54	Infant Outcome Report
_____	DMAS-55	Care Coordination Letter of Agreement
_____	DMAS-70	Practitioner Referral Form
_____	DMAS-77	ICF/MR Utilization Review Assessment
_____	DMAS-77A	Programs/Objective Continuation Sheet
_____	DMAS-80	Personal Care Recipient Admissions Envelope
_____	DMAS-90	Personal Care Aide Record
_____	DMAS-95	Assessment Process
_____	DMAS-95MI/MR	Supplemental Assessment Process Form
_____	DMAS-96	Nursing Home Pre-Admission Screening Plan
_____	DMAS-97	Plan of Care for Personal Care Services
_____	DMAS-97A	Provider Agency Plan of Care
_____	DMAS-98	Documentation of R.N. Supervisory Visit
_____	DMAS-99	Recipient Progress Report
_____	DMAS-108	Transportation Preauthorization Form
_____	DMAS-119	Social History Form
_____	DMAS-121	Certificate of Patient Status
_____	DMAS-121-A	Certificate of Patient Rehabilitative Services
_____	DMAS-122	Patient Information
_____	DMAS-200	Appeal to Medical Assistance Appeals Board
_____	DMAS-201	Notification of Medicaid Transportation Denial
_____	DMAS-212	Title XIX Enrollment
_____	DMAS-300	Respite Care Needs Assessment and Plan of Care
_____	DMAS-301	Adult Day Health Interdici]linary Plan of Care
_____	DMAS-302	Adult Day Health Care Daily Log
_____	DMAS-351	Request for EPSDT Services
_____	DMAS-353	EPSDT Documentation Form
_____	DMAS-403	Title XIX Admission Certification Psychiatric Hospital
_____	DMAS-408	Preauthorization Request for Non-Covered New Drug
_____	DMAS-412	Medicaid Request for Psychiatric Extension Treatment
_____	DMAS-420	Request for Hospice Benefits
_____	DMAS-421	Hospice Benefits Revocation/Change Statement
_____	DMAS-440	Request for Authorization of DME and Supplies
_____	DMAS-450	Request for Authorixation of Extended Home Health Services
_____	DMAS-999	Third Party Liability Information Report
_____	DMAS-1000	Third Party Liability Information Report
_____	DMAS-3004	Sterilization Consent Form
_____	DMAS-3005	Acknowledgement of Receipt of Hysterectomy Information
_____	DMAS-3006	Abortion Certification
_____	DMAS-4000	Prosthetic Device Preauthorization Form

Quantity	Form Number	Brochure Name
_____	DMAS-1	Medicaid Health Checkup Program
_____	DMAS-2	Virginia Medicaid Handbook
_____	DMAS-4	"Spend-Down" Sheet
_____	DMAS-60	BabyCare (English)
_____	DMAS-61	BabyCare (Spanish)
_____	DMAS-62	BabyCare (Vietnamese)
_____	DMAS-63	BabyCare (Laotian)
_____	DMAS-64	BabyCare (Cambodian)
_____	DMAS-66	Emergency Care
_____	DMAS-67	Planning Ahead: A Guide for Virginians with Disabilities

Please return this form to: Provider Enrollment/Certification Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS-161 R 11/90